MVP FASTFAX

News for West Region — Rochester/Buffalo Providers

Please review the information below related to Utilization Management. All of the information presented is in effect January 1, 2016.

PRIOR AUTHORIZATION REQUESTS

Effective 1/1/16 all requests for authorization must be done via fax.

Please complete the UM Prior Authorization Request Form (PARF) and fax it along with the corresponding clinical documentation necessary for it to be reviewed by our clinical team. The request form can be found at **www.mvphealthcare.com/provider** under *Forms.*

Please fax to the appropriate number:

Prior Authorization Requests, Out-of-Network Requests, Notification of Urgent Admissions	**1-800-280-7346**
Clinical Documentation for Concurrent Hospital Admissions	**1-888-207-2889**
Outpatient Physical, Occupational or Speech Therapy	**1-914-372-2411**
Durable Medical Equipment, Prosthetics and Orthotics	**1-888-452-5947**
Homecare and Home Therapy	**1-914-372-2434**
Skilled Nursing or Acute Inpatient Rehab	**1-866-942-7826**
Retrospective, Physician Claim Review or DRG Reviews	**1-518-386-7417**
Personal Care /CDPAS & Long Term Nursing Home (Medicaid Only)	**1-914-372-2433**

SERVICES REQUIRING PRIOR AUTHORIZATION:

Effective January 1, 2016, some services requiring prior authorization will change. The UM Policy Guide may be viewed under *Reference* after you *Log In* or *Register* for an online account at **www.mvphealthcare.com/provider**. It is important to refer to the specific medical policy in the Benefits Interpretation Manual (BIM) that is located under the same *Reference* area.

SERVICES REQUIRING RETROSPECTIVE REVIEW OR THE POTENTIAL FOR RETROSPECTIVE REVIEW:

It is important to refer to the specific medical policy in the Benefits Interpretation Manual (BIM) to determine whether a service requires prior authorization, retrospective review, or whether there is a potential for retrospective review. After you *Log In* or *Register* for an online account at **www.mvphealthcare.com/provider**,select *Reference*.

Look at the end of the medical policy for the member's Product and Medical Management requirements. Services that are indicated that require retrospective review means that the services must still be medically necessary and will be reviewed post-service, pre-claim payment. Members are not held financially responsible for services that are not medically-necessary. Services that indicate a potential for retrospective review or any service that does not otherwise have review requirement will be monitored for trends in utilization and may be audited at any time by MVP.

Questions? Please contact the Customer Care Center for Provider Services. Representatives are available weekdays from 8:30 a.m. – 5:00 p.m. Eastern Time at 1-800-999-3920.

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